METASTAR

EQRO Annual Report

The Wisconsin Family Care Program
2005/2006

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to

The Wisconsin Department of Health and Family Services

by

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Executive Summary

Wisconsin's managed health and long-term care programs, including the Family Care program, are considered pre-paid inpatient health plans (PIHPs). As such, they are subject to regulations set forth in the Balanced Budget Act of 1997 (BBA). Sections 1932(c)(2) and 1903(a)(C)(ii) of the Social Security Act, which were enacted in sections 4705(a) and 4705(b) of the BBA of 1997, require the services of an external quality review organization (EQRO). The role of the EQRO is to review, analyze, and evaluate aggregated information about the health and long-term care services furnished to individuals enrolled in the Medicaid managed care program. The Department of Health and Family Services (the Department) contracts with MetaStar, Inc. (MetaStar) to conduct external quality review (EQR) activities for the Family Care program.

The Department contracts with care management organizations (CMOs) that administer the Family Care program in the State of Wisconsin. MetaStar's review activities are designed to evaluate the services that are arranged for or provided to enrollees or potential enrollees under the contracts the Department has with CMOs.

In 2005, MetaStar conducted four required review activities listed below.

- On-site visits to assess the CMO's compliance with State and Federal Quality Standards
- Validation of CMO-reported performance measures
- Validation of CMO performance improvement projects and technical assistance with their quality improvement efforts
- Member file reviews to assess the CMO's service and support coordination

Member Choice

A goal of the Family Care program is to give people better choices about the supports and services available to meet their needs. Creating and fostering a culture that supports a member-centered approach to service planning and service delivery is a key component to achieving this Family Care goal. Review findings from 2005/2006 show that CMOs have fully embraced this philosophy, creating a strong member-focused approach to care management. CMOs are skilled at identifying members' desired outcomes and preferences and incorporating them into unique member-centered plans. Results from the member centered assessment and plan review found member preferences and desired outcomes are addressed by interdisciplinary teams 99.5% of the time.

Members also choose which service providers they want to use within the CMO's provider network. To help facilitate this choice, CMOs are responsible for providing members with new and updated provider directories. Although most CMOs do provide these directories to members, they do not always include contractually required information.

The Family Care program is also designed to assure certain rights for members. Providing members with information about their rights enables members to make informed decisions about the care and services they choose to receive. A review of how CMOs assure members' rights showed that CMOs do this in several ways. First, CMOs make their handbooks accessible to members who have special needs. Handbooks are available in prevalent languages and in Braille. One CMO even provides its members with "quick reference" handout of key information from the member handbook.

CMOs also ensure member rights by providing information about completing advance directives. Having an advance directive in place helps to ensure that a member's wishes are upheld when they are unable to express those wishes. All CMOs were found to have mechanisms in place to provide members with information about advance directives. Two CMOs conducted performance improvement projects aimed at increasing the number of members with advance directives in place.

Members also have certain rights regarding the use of isolation, seclusion and/or restraints. Wisconsin State statutes and the Wisconsin Administrative Code require compliance in the use of isolation, seclusion and physical restraints. In 2006, CMOs were found to have policies drafted to address the use of isolation, seclusion and/or restraints on members. They are currently awaiting necessary language from the Department before finalizing these.

Access to Services

Another important goal of the Family Care program is to improve people's access to health and long-term care services. In their contract with the CMOs, the Department identifies several ways for the CMO to demonstrate that they can provide needed services to members. One way is through the establishment of an adequate network of service providers. Establishing adequate provider networks is an area that all CMOs continue to make good progress in. CMOs do geographic mapping to identify where providers are located in relationship to members. Most CMOs have established standards for travel time and distance, and they monitor for gaps in service provider coverage. CMOs also use out-of-network providers to address service gaps and expand the range of services available to members. One challenge faced by CMOs is in monitoring the capacity of providers to offer services to new or additional members in a timely manner.

Another way of assuring that members have access to needed services is for the CMO to have an effective process for authorizing services. All CMOs use the resource allocation decision (RAD) method to authorize services. If a service is not authorized, or if it is authorized in an amount less than requested or even denied, a notice of action must be issued. The primary purpose of the notice of action is to advise members of their appeal and grievance rights when services are terminated, limited or denied. MetaStar reviewers found that these notices were not always issued when indicated. Member-Centered Assessment and Plan (MCAP) review findings showed that notices of actions were issued when indicated only 70.6% of the time. This was also noted during interviews with key CMO staff and members. CMO staff indicated that they did not have consistent processes in place to ensure timely or consistent use of the RAD method. CMO members indicated that they did not always receive a notice of action when services were

terminated, limited or denied. Over the past three years CMOs have failed to make progress with issuing notices of action when indicated.

Quality

Improving the overall quality of the long-term care system by focusing on members' personal outcomes is another goal of the Family Care program.

To ensure ongoing quality, CMOs are required to develop a quality assurance/quality improvement (QA/QI) program that includes an annual QA/QI work plan. The Department also requires each CMO to evaluate their prior year's QA/QI work plan before developing their work plan for the next year. In 2005, only two CMOs used annual QA/QI program evaluations to help set goals for the upcoming year.

CMOs can identify other areas in need of improvement by collecting member feedback and conducting satisfaction surveys. In 2005, three CMOs conducted member satisfaction surveys by phone or through mailings. Two CMOs did not conduct a satisfaction survey or collect member feedback in any other way. The Department did request that all CMOs develop a plan for conducting satisfaction surveys or collecting member feedback by some other means in their 2007 QA/QI work plans.

An internal monitoring system that includes periodic file reviews to evaluate the quality of care management being provided can help the CMO identify unacceptable patterns of practice within the organization. Most CMOs have instituted some type of internal file review process for this purpose. However, it was evident during MCAP reviews and the onsite visits that CMOs are not always compiling and analyzing the data they obtain.

Using data to help improve quality is dependant on having valid, reliable data. One of the required review activities that MetaStar conducted in 2005 was to determine if CMOs are reporting valid data to the Department. Each year, CMOs must report certain performance measure data to the Department and MetaStar. MetaStar then validates this data to determine if the CMO is reporting accurate data. In 2005, MetaStar found that all CMOs successfully reported valid immunization and care management team turnover rates to the Department.

When data confirms that a specific area is in need of improvement, a performance improvement project can be initiated. The Department requires each CMO to conduct two performance improvement projects (PIPs) annually. These projects must be implemented or completed within a reasonable time period. Each CMO initiated two PIPs in 2005; however one CMO was unable to fully implement one of its projects due to ongoing staffing issues. Each CMO selected appropriate projects that focused on improving member's health and social outcomes. These projects focused on topics such as improving diabetes outcomes and increasing the rate of members who have an advance directive for healthcare in place.

The following report provides an overview of the purpose, background, methodology, findings and analysis for each of the four required review activities.

I. Introduction

Background

Wisconsin's managed health and long-term care programs, including the Family Care program, are considered pre-paid inpatient health plans (PIHPs). As such, they are subject to regulations set forth in the Balanced Budget Act of 1997 (BBA). Sections 1932(c)(2) and 1903(a)(C)(ii) of the Social Security Act, which were enacted in sections 4705(a) and 4705(b) of the BBA of 1997, require the services of an external quality review organization (EQRO). The role of the EQRO is to review, analyze, and evaluate aggregated information about the health and long-term care services furnished to individuals enrolled in the Medicaid managed care program. Federal regulations 42 CFR Part 438 Subpart E – External Quality Review requires that the following activities be performed annually for PIHPs:

- Determine the PIHP's compliance with Federal and State managed care quality standards
- Validate the PIHP's performance measures
- Validate the PIHP's performance improvement projects
- Assess the quality of the PIHP's service and support coordination functions

The Center for Medicare and Medicaid Services (CMS) has established protocols that guide these review activities. One such protocol is *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, et al.* Overall, review activities involve assessing the timeliness, access to and quality of the long-term supports and services that the organization provides. Some activities are designed to assure that the PIHP is meeting minimum standards and/or requirements, while others are designed to evaluate how effectively the organization is identifying and achieving member outcomes. Additional activities are designed to identify areas for improvement.

EQR Activities in Family Care

The Department of Health and Family Services (the Department) contracts with care management organizations (CMOs) that administer the Family Care program in the State of Wisconsin. The Department also contracts with MetaStar, Inc. (MetaStar) to conduct external quality review (EQR) activities for the Family Care program. MetaStar's quality review activities are designed to evaluate the services that are arranged for or provided to enrollees or potential enrollees under the contracts the Department has with CMOs.

The quality activities in 2005 included four review activities required by federal regulations as well as five optional activities. The four required activities are:

- Conducting on-site visits to assess the CMO's compliance with State and Federal Quality Standards
- Validating CMO-reported performance measures
- Validating CMO performance improvement projects and providing CMOs with ongoing technical assistance with their quality improvement efforts

- Conducting member file reviews to assess the CMO's service and support coordination

Upon request of the Department, MetaStar also conducted these optional activities:

- Assuring the integrity of the Long-Term Care Functional Screen by reviewing results of screener competency testing
- Reviewing CMO-reported unexpected deaths
- Investigating appeals and grievances reported to the Department
- Conducting on-going review of Milwaukee County CMO actions related to reductions in supportive home care hours

This report details the required review activities that MetaStar conducted of the Family Care program between July 1, 2005, and June 30, 2006. Findings from optional reviews have been fully reported under separate cover and are referenced in this report if needed to support other findings.

MetaStar strives to make the EQR process a collegial interaction. Its goal is to improve the quality of health and long-term care services provided to enrollees and potential enrollees of Wisconsin's managed health and long-term care programs.

II. Determining Compliance with Federal Medicaid Managed Care Regulations

Background/Purpose of Review Activity

The purpose of the 2006 Annual Quality Review (AQR) of the Family Care program Care Management Organization (CMO) is to determine whether the CMOs comply with Federal Medicaid Managed Care Regulations. MetaStar conducted this review according to Federal Regulation 438, Subpart E, using CMS' Final Protocol Version 1.0, cited above on page 4.

The AQR process will identify, document, and review the CMOs' practices related to quality and timeliness of, and access to, care and services provided to CMO members. Five main topic areas constitute the protocol, and MetaStar reviewed all areas in 2006:

- Enrollee rights
- Quality assessment and performance improvement: Access
- Quality assessment and performance improvement: Structure and operations
- Quality assessment and performance improvement: Measurement and improvement
- Grievance systems

Review Methodology

In past years, MetaStar reviewed only some of the five main review areas during its annual quality site visit. However, the reviews sometimes revealed that the CMOs were experiencing difficulties in areas other than those targeted for review. Therefore, for this review period, MetaStar performed a comprehensive review of all areas of the protocol. The 2006 CMO Annual Quality Review incorporated the following activities:

Collecting Background Information

MetaStar reviewed the 2006 Health and Community Services contract between the Wisconsin Department of Health and Family Services Division of Disability and Elder Services and the CMO. The Department also provided MetaStar with information pertaining to federal regulatory requirements.

Conducting Document Review

The CMOs were asked to submit all documents to the Department before their on-site visit. They did not have to resubmit any documents provided for the 2005 CMO Certification process or the 2005 Member Centered Assessment and Plan (MCAP) review process, as long as the documents had not changed. Reviewers assessed the CMO's documents prior to the on-site visit. This allowed them to tailor questions for each CMO based on their review.

Conducting On-site Interviews

MetaStar conducted interviews with CMO staff representing a wide range of organizational departments and functions. MetaStar also asked to interview six members at each CMO. The CMO chose the members to be interviewed, using the following criteria:

- Two members enrolled within the past 3 -5 months.
- Two members with complex needs or conditions (such as multiple health or service needs, skilled nursing, quadriplegia, etc.) who had been enrolled in the CMO for at least 1½ years
- Two members who had filed an appeal or grievance at the CMO level.

MetaStar interviewed 26 members to learn more about how the CMO responds to members and helps to support member outcomes. Four members were unavailable at the scheduled interview times (two in La Crosse, and two in Milwaukee).

Collecting Supplemental Information

Based on information gathered during the on-site visit, MetaStar asked for and reviewed additional documents to clarify the findings from the review.

Analyzing and Compiling Findings

MetaStar used a three-point rating structure ("met," "partially met," and "not met") to assess the level of the CMOs' compliance with standards specified in the review protocol.

- **Met** applied when all policies, procedures, and practice aligned to meet the specified requirement.
- **Partially met** applied when the CMO met the requirements in practice, but did not have directly relevant written policies or procedures; and when the CMO had draft policies that had not been finalized or implemented.
- **Not met** applied when the CMO did not meet the requirement in practice and had not addressed it in policy or procedure.

Reporting Evaluation Results to the Department

The Department uses the reports to determine how well the CMOs comply with their contracts. The Department requires any CMO with a "partially met" or "not met" rating to develop an improvement plan or to conduct other follow-up for the area.

Findings & Analysis

Enrollee Rights

The table below reflects final findings for each CMO for the enrollee rights standards.

CMO	2006 Enrollee Rights Standards			
	Fully Met	Partially Met	Not Met	Total
Fond du Lac	30	4	0	34
La Crosse	29	4	1	34
Milwaukee	29	5	0	34
Portage	32	2	0	34
Richland	33	1	0	34
Total	**153 (90%)**	**16 (9.4%)**	**1 (0.6%)**	**170**

The CMO has a responsibility to help its members understand their rights. Providing members with information about their rights enables them to make decisions about the care and services they receive. Key activities related to enrollee rights include the provision of member handbooks and provider network directories; educating and assisting members with advance directives; and ensuring that isolation, seclusion and restraints are initiated only when appropriate.

Member Handbooks

The CMO member handbook contains all the key information members need about their rights and responsibilities. Members should receive their handbook from the Resource Center before they enroll. The CMO's interdisciplinary team will follow up during its first home visit to ensure the member has a handbook and will provide another copy as needed. Nevertheless, three of the five CMOs did not have written policies or procedures for staff about distributing information to enrollees about their rights. The other two CMOs stated that they do tell staff what is expected of them related to distributing information to members about their rights, but they did not provide any written policies or procedures to MetaStar. One CMO reproduces key information from the member handbook onto a double sided page and gives it to members as a quick reference. Reviewers stressed the importance of developing written policies and procedures to ensure staff consistently distribute enrollee rights information to members.

All CMOs make their handbooks accessible to members who have special needs. Three CMOs (Fond du Lac, Milwaukee and La Crosse) have translated the member handbook into other languages. Teams at all CMOs arrange for interpreters to attend home visits with them so they can translate documents in person, and one CMO has contracted with a translation service to translate documents when needed. All CMOs can print documents in large print or provide adaptive equipment for members with visual impairments. One CMO can produce materials in Braille.

The members who were interviewed reported that they received a member handbook when they enrolled. Three members stated they had difficulty reading the handbook due to visual impairments. Those members had not received and had not asked for adaptive equipment that

would help them read the handbook. The interviewers encouraged members to request adaptive equipment from their teams. The CMOs should ensure teams are aware of the availability of handbooks in alternate formats.

Provider Network Directory

Members can choose which service providers they want to use within the CMO's network of providers. However, the provider network directories that members receive do not consistently include all information that the CMO's contract requires. As a result, it may be difficult for members to make informed choices about providers. For example, the listing at two CMOs failed to indicate the non-English languages spoken by the providers, provider limitations on accepting new patients/members, and any physical accessibility concerns. One CMO (Richland) did not include provider phone numbers, specialty care provided, non-English languages spoken or provider limitations in the provider directory. While the CMO stated that they did this to prevent members from seeking what might be ineffective or inappropriate services on their own, it creates a barrier for informing members of providers who can meet their language needs.

Advance Directives

The member handbook includes information on members' ability to create advance directives, and this right is emphasized during the enrollment process. Advanced directives can help ensure that a member's wishes are upheld when they are unable to express those wishes themselves. Most CMOs revisit the subject with members who do not have advanced directives in place during six-month care plan reviews or during the annual reassessment process.

Two CMOs are conducting performance improvement projects aimed at increasing the number of members with advance directives for healthcare. These CMOs are tracking members with and without advanced directives in place and have initiated strategies to increase the number of members with advanced directives completed. Some CMOs do not have a process in place to document information about advance directives even though it is a contract requirement. The lack of documentation may create a conflict if a member does have an advance directive and it is not relayed to a health care provider.

None of the CMOs had relayed information to members on how to file a complaint regarding non-compliance with an advance directive. This finding was relayed to the Department and the CMO's contract for 2007 will direct CMOs to inform members of the process, which is to contact the Bureau of Quality Assurance.

CMOs are also required to educate the community about advance directives, but they feel that the Resource Center (RC) staff should be responsible for those activities. CMOs do provide support to the RC related to educating the community on advanced directives; however, they do not have a way of documenting that support.

Isolation, Seclusion and Restraints

CMOs and their subcontracted providers must comply with State statutes and the Wisconsin Administrative Code in the use of isolation, seclusion and physical restraints on members. These

methods may not be used or initiated without the Department's case-by-case approval. Three CMOs have draft policies and procedures about the use of restraint measures and are waiting for the Department to provide language about the procedure for requesting approval to use physical or chemical restraints. The Department should provide the necessary language to the CMOs so they can finalize and implement their draft policies regarding the use of isolation, seclusion and physical restraints on members.

QA/PI: Access to Services

The table below reflects final findings for each CMO for the access to services standards.

CMO	2006 QA/PI: Access to Services Standards			
	Fully Met	Partially Met	Not Met	Total
Fond du Lac	21	3	0	24
La Crosse	22	2	0	24
Milwaukee	18	4	2	24
Portage	23	1	0	24
Richland	23	1	0	24
Total	**107 (89.2%)**	**11 (9.2%)**	**2 (1.7%)**	**120**

In their contract with the CMOs, the Department identifies several ways for the CMO to demonstrate that they can provide services to their members. One way is through the establishment of an adequate network of service providers. The contract with the Department requires all CMOs to develop a provider network that is large enough, has a broad enough geographic distribution and a wide enough range of services to serve their members. Another way of assuring access to services is to have an effective process for authorizing services for members.

Provider Network

Each CMO does geographic or zip code mapping that identifies where providers are located in relation to its members. Also, four of the five CMOs have established standards for travel time and distance to ensure members have adequate access to a range of providers. If a CMO identifies a gap in its network, it will strive to add providers in the affected area of the county. All CMOs use out-of-network providers to "fill" geographic gaps and expand the range of available services and will try to add them to the network when it will benefit the members.

Geographic or zip code mapping identifies only where providers are located in relation to members. It does not indicate whether the providers can actually serve members. Only some of the CMOs proactively monitor limitations on providers' capacity. Often, when teams attempt to arrange services, they find that a provider is no longer accepting new referrals or may not be able to provide services in a timely manner. When services are delayed, there is a potential for health and/or safety issues to arise. To ensure members have timely access to providers, CMOs need to develop methods and processes for tracking provider capacity and then determine if providers need to be added to the network.

Service Authorization

Interdisciplinary teams arrange services for members based on member preferences or requests, or when needs for services are identified through the assessment process. The Department specifies that the team reach a decision on a member's service request within 14 days after receiving the request. All CMOs have adopted the Resource Allocation Decision (RAD) method as their service authorization process; however, several CMOs do not have procedures in place to ensure that the RAD is used consistently by all teams.

At most CMOs, once services are authorized, teams do not have a consistent method of following up to ensure that services are implemented in a timely manner or implemented at all. In addition, two of the CMOs have not even defined what "timely" means.

Most members interviewed stated that they were given choices about needed services and providers, which they sometimes deferred to their teams. Members at the Fond du Lac CMO said that the CMO usually made the decision about their services and providers. They believed the CMO chose the "cheapest" providers, because their teams often talked about costs. This practice creates an environment where members feel they have no choice about the services they receive. This is contradictory to a true member-centered approach to care and to one of the goals of the Family Care initiative (to have choice of services).

Reviewers encouraged CMOs to implement procedures, such as an internal file review process, to monitor the use of the RAD method. Results of such a process will enable CMOs to determine if decisions on service requests are made within the contract required timeframes, and if teams are consistently including the member in the decision-making process.

QA/PI: Structure and Operations

The table below reflects final findings for each CMO for the QA/PI structure and operations standards.

CMO	2006 QA/PI: Structure and Operations Standards			
	Fully Met	Partially Met	Not Met	Total
Fond du Lac	13	1	0	14
La Crosse	11	2	1	14
Milwaukee	10	2	2	14
Portage	14	0	0	14
Richland	14	0	0	14
Total	**62 (88.6%)**	**5 (7.1%)**	**3 (4.3%)**	**70**

Creating standard policies and procedures for key processes can improve the performance of those processes, several of which are tied to contract requirements.

Provider Contracting

A key process in developing the provider network is the initial contracting and re-contracting of providers, which CMOs perform each year. As CMOs contract with several hundred providers, they must have a process for selecting, retaining, and certifying providers, in order to effectively

maintain their provider network. Four of the five CMOs have a documented process for initial contracting and recontracting of providers. The contracting process includes standards providers need to meet in order for the CMO to extend a contract. For example, CMOs require providers to have proof of liability insurance, license, Medicaid certification or accreditation status, as well as policies and procedures for conducting criminal background checks on employees.

The Milwaukee CMO has developed a draft policy and procedure for selecting, retaining, and credentialing providers, which is not yet implemented. The Milwaukee CMO is the largest CMO and it contracts with over 600 providers. Without a standardized process for ensuring contracted providers are complying with requirements, the CMO may not be ensuring a member's health and safety. The CMO did state it intends to finalize and implement the draft policy in late 2006. Also, only one CMO has defined a process for notifying providers in writing of the reasons the CMO has decided not to contract with them. All CMOs were directed to include the notification step into the policy and procedure which would allow providers to rectify any deficiencies in order to meet contracting expectations.

Delegation and Outsourcing

The Milwaukee CMO outsources certain functions to other entities. These functions include quality review services, third-party administration of claims processing, IT technical support, and the hiring of a CFO and COO. According to the contract with the Department, the CMO is required to complete a written evaluation of each delegated subcontractor each year. However, the CMO has been unable to effectively evaluate the subcontractors because it does not have a process for monitoring them. The CMO stated that it was developing such a process, and planned to use the process to evaluate the subcontractors in early 2007.

The Milwaukee CMO also contracts with Care Management Units (CMUs) to provide case management services for members. Organizations that provide long-term care services (such as adult day services, home health care, supportive home care, etc.) to persons who live in Milwaukee County operate the CMUs. The CMO's contract with each CMU requires case management staff to have bachelor's degrees in the social services area or in nursing. However, when MetaStar reviewed the educational backgrounds of the care management staff and supervisors at three CMUs, it found that that some staff did not have the required degrees. The Milwaukee CMO was not aware of this because it had not developed nor implemented a process to ensure the CMUs are complying with the requirements for hiring practices. A recommendation was made to develop a process for monitoring the educational backgrounds of all CMU care managers to ensure that all possess the required Bachelor's degree. In addition, when educational background deficiencies are discovered, the CMO should establish a corrective action plan to ensure that contract requirements are met.

Background Checks

The Department's contract requires the CMO to conduct criminal and other background checks on any provider or staff who comes into direct contact with a member. All CMOs have processes in place to verify that their providers are doing criminal background checks on their employees. In addition, they help members use the Self-Directed Supports (SDS) option to hire and employ their own caregiver by getting the results of background checks before hiring a

certain provider. However, the La Crosse CMO is not conducting criminal background checks on employees of its own who come into direct contact with its members. The CMO has relayed this oversight to the county and it stated that beginning in 2007, all La Crosse county employees (which includes CMO employees) will have initial criminal background checks completed.

Disenrollment of Members

When a member expresses a desire to disenroll from the CMO, teams are not supposed to talk with the member about disenrollment, but must immediately refer him or her to the Resource Center for counseling about disenrollment options. The disenrollment policies and procedures of all CMOs include this restriction. If a member elects to disenroll from the CMO, the team's role is to ensure that transition plans are in place for the member's services and supports. CMO management confirmed that teams provide members with information about returning to the fee-for-service system, and contact agencies in the counties in which members are moving to coordinate services.

CMOs track rates and reasons for disenrollment. The CMOs report their analysis has not revealed any trends and indicate that death is the most common reason for disenrollment.

QA/PI: Measurement and Improvement

The table below reflects final findings for each CMO for the QA/PI measurement and improvement standards.

CMO	2006 QA/PI: Measurement and Improvement Standards			
	Fully Met	Partially Met	Not Met	Total
Fond du Lac	12	4	0	16
La Crosse	15	1	0	16
Milwaukee	6	1	9	16
Portage	13	3	0	16
Richland	10	4	2	16
Total	**56 (70%)**	**13 (16.2%)**	**11 (13.8%)**	**80**

Quality Assurance/Quality Improvement Plans

When first contracting with the Department, each CMO was required to develop a quality assurance/quality improvement (QA/QI) program that included a QA/QI workplan for the coming year. The QA/QI program needed to address three activities: (1) conducting performance improvement projects, (2) developing and implementing processes to monitor for under- and over-utilization of services, and (3) developing and implementing processes to monitor and assess the quality and appropriateness of care furnished to Family Care members. The CMO updates its QA/QI workplan each year, identifying new goals and objectives for those activities. The Department approves each CMO's QA/QI workplan annually as part of the CMO recontracting process.

The Department also requires each CMO to evaluate their prior year's QA/QI workplan before developing their workplan for the next year. Evaluating its progress on the prior year's quality

improvement efforts helps the CMO develop goals for the coming year's workplan. Two CMOs have used these annual evaluations to help set goals for the upcoming year. However, not all CMOs have done this. In fact, one CMO developed their 2006 workplan and gained board approval for it before fully evaluating their 2005 workplan. To date, that CMO still has not updated its 2006 workplan to reflect its evaluation of the 2005 workplan. Another CMO (Richland) has not incorporated the results of its 2005 workplan into its 2006 workplan, and their workplan has still not been approved by the Department. The Milwaukee CMO only recently received the Department's approval on its 2006 workplan, but has not yet implemented it.

Prevention and Wellness Activities

Adopting guidelines for clinical practice is a key activity in a CMO's annual QA/QI workplan. Clinical practice guidelines help teams plan member's care, and need to be updated annually as best practice standards change over time. Most CMOs have developed and implemented clinical practice guidelines. However, only one CMO has implemented mechanisms to monitor the consistent use of the guidelines. The Milwaukee CMO has not yet developed or implemented any clinical practice guidelines, although it has identified several priority guidelines to develop. An opportunity exists for CMOs to monitor the use of clinical practice guidelines to ensure that teams are using them to guide care planning and that they are using them correctly.

When asked about assistance with health concerns, members reported that their teams allow them to set up their own medical appointments. Team members sometimes go to the appointment with members, help with transportation needs, obtain releases from physicians to share laboratory results and physician notes with the CMO, and educate members about the risks of not following medical advice. However, in some instances, the team nurse did not always follow up with the member after an appointment, which may result in a lack of coordination of primary care services. CMOs were encouraged to relay expectations to team nurses regarding follow up activities after a member had an appointment. Monitoring follow-up activities of nurses could be done through an internal file review process.

Performance Measures

Another activity detailed in the QA/QI workplan is the reporting of performance measure data to the Department and MetaStar. The review of performance measures is done to ensure that CMOs are collecting and reporting valid and reliable data. The performance measures that CMOs must report on are influenza vaccination rates, pneumonia vaccination rates, and the turnover rate of care management staff. After this data is reported by the CMO, MetaStar reviews the CMO's information technology systems to assess how it documents, collects, and reports the data needed for the required performance measures. MetaStar then provides technical assistance to all of the CMOs regarding data management and reporting. Two CMOs do not have processes in place to ensure that the measures are documented in a standardized format. One CMO did not have a procedure in place to ensure that it was excluding members who should not receive a vaccination in the reported vaccination rates. However, all data reported was found to be valid and reliable.

Member Feedback

CMOs can identify other areas in need of improvement by collecting member feedback and conducting satisfaction surveys. Three CMOs conducted member satisfaction surveys by phone or through mailings. The Fond du Lac CMO is working with Marion College to re-design the member survey to yield more meaningful data to help identify areas in need of improvement that could be incorporated into their QA/QI workplan; it plans on conducting a member survey in 2006. The Richland and Portage CMOs did not conduct a satisfaction survey of its members, nor did it gather member feedback by any other means in 2005. To comply with the contract with the Department, CMOs were reminded to detail a means to gather member feedback through a satisfaction survey or other ways in their 2007 QA/QI workplans.

Although very few of the members who were interviewed recalled receiving a written satisfaction survey from their CMO, they did say that their teams informally evaluate their level of satisfaction with the services being provided to them. This informal assessment of member satisfaction can help determine whether the services provided are effectively meeting the member's expectations and outcomes.

Internal File Reviews

Procedures for conducting internal file reviews can help the CMO identify whether its staff is following acceptable care management processes. Most CMOs have instituted some type of internal file review process. However, not all CMOs have been collecting or analyzing data on the results of the review process. For example, some CMOs are not capturing information about whether teams are making service authorization decisions within the mandated timeframe (14 days). Also, two CMOs are not using information gained from file reviews to ensure that teams are using the service authorization process consistently. One CMO is not monitoring care plans to ensure that members' health care services are being effectively coordinated. Collecting and analyzing file review data can help a CMO identify areas needing improvement. A strong internal monitoring system that includes conducting periodic file reviews, can allow a CMO to identify unacceptable patterns of practice early and take steps to correct them.

Grievance Systems

The table below reflects final findings for each CMO for the grievance systems standards.

CMO	2006 Grievance Systems Standards			
	Fully Met	Partially Met	Not Met	Total
Fond du Lac	41	1	0	42
La Crosse	40	2	0	42
Milwaukee	40	1	1	42
Portage	42	0	0	42
Richland	41	1	0	42
Total	**204 (97.1%)**	**5 (2.4%)**	**1 (0.5%)**	**210**

Appeal and Grievance Process

Findings from the review of the appeal and grievance process indicate that the CMOs have well established written documentation that is implemented at all levels of the organizations. The review found very few "partially met" or "not met" ratings. This finding is supported by the review of appeals and grievances that members filed with the Department or with the Division of Hearing and Appeals (see Attachment A for a review of appeal and grievance investigations completed by MetaStar).

CMOs report that communication and informal problem solving/mediation at the team level has helped to limit the number of formal appeals and grievances being filed. Most teams educate members about their appeal rights when they present a notice of action related to a termination, limitation or denial of service.

However, not all members interviewed were aware of the appeals and grievance process or of their rights related to filing appeals and grievances. The contract with the Department states that members may file an appeal or grievance at the local, State or Fair Hearing level, and this information is provided to members in their handbook and is reviewed at the time of enrollment in the CMO. However, several members said that they felt that if the CMO denied a request, the decision was final and they could not make the request again. Some members reported that they did not always receive a notice of action when services were denied, limited or reduced. One member did not know that he could file an appeal through the State or the Fair Hearing level, or that he could file an appeal on more than one issue at a time.

An opportunity exists to improve communication of the appeal and grievance process to members. This could be done during the six-month care planning process or annually when updated member handbooks are distributed. The goal is to ensure members are aware of their rights to file an appeal or grievance and the ability to file at any or all levels.

Appeal and Grievance Timeframes

When the CMO denies, reduces or terminates a service, it is required to issue a notice of action to members, which specifies their appeal and grievance rights. CMOs are required to give members a certain amount of time to file an appeal or grievance after receiving a notice of action. Two CMOs need to clarify appeal and grievance timeframes: one by including the same deadlines in all its documents, and the other by defining when the timeframe for resolution begins. Also, two CMOs are not tracking timeframes for notices of action. As a result, members may not be receiving adequate notice in order to exercise their appeal rights.

If the CMO can not make a decision on the member's request within the 14 day timeframe and the member does not agree to the extension, the CMO must issue a denial notice to the member. One CMO does not consistently inform members when the CMO is requesting an extension of the 14 day timeframe related to decision-making.

The appeal and grievance process seems to be working at the front-end with teams and members identifying solutions together. There seems to be a process breakdown for all CMOs with a lack of notices of action being provided to members and a lack of monitoring timeliness of response

to service requests. To ensure members are able to exercise their rights, CMOs should develop a tracking system for the provision of notices of action and timeliness of decision-making.

Summary

Findings from the annual quality reviews show that most CMOs have developed comprehensive policies, procedures, forms, tracking mechanisms and feedback loops that comply with the Department's contract. On average, quality standards were met approximately 90 percent of the time for all programs, across all five protocol review areas. Across all CMOs, full compliance with standards in the measurement and improvement area was only 70 percent, while full compliance with grievance systems standards was nearly 100 percent.

Protocol Review Areas	2006 Aggregate AQR Findings			
	Fully Met	**Partially Met**	**Not Met**	**Total**
Enrollee Rights	153 (90%)	16 (9.4%)	1 (0.6%)	170
QA/PI: Access to Services	107 (89.2%)	11 (9.2%)	2 (1.7%)	120
QA/PI: Structure and Operations	62 (88.6%)	5 (7.1%)	3 (4.3%)	70
QA/PI: Measurement and Improvement	56 (70%)	13 (16.2%)	11 (13.8%)	80
Grievance Systems	204 (97.1%)	5 (2.4%)	1 (0.5%)	210
Total	**582 (89.5%)**	**50 (7.7%)**	**18 (2.8%)**	**650**

The CMOs were directed to develop Improvement Plans to address all "partially met" and "not met" areas, and include timeframes for completion of the follow-up actions noted in their respective report. Issues that needed to be addressed fell into the following five categories:

- Adequacy and appropriateness of member services (2 issues identified);
- Qualifications of direct care worker staff (1 issue identified);
- Member access to services (6 issues identified);
- Quality management of member services (34 issues identified); and
- Development or amendment of policies and procedures (21 issues identified).

Items that fall into the first two areas directly affect members and need immediate attention. These three items relate to the verification of care managers' educational backgrounds (Milwaukee CMO), implementation and monitoring of the Provider Credentialing Policy with on-site visits to providers (Milwaukee CMO) and completion of criminal background checks on CMO employees (La Crosse CMO).

Items in the other three areas need correcting, but there is no evidence that they have so far adversely affected members. Issues related to member access to services include the need for implementing a tracking system to verify that notices of action are mailed to members within contract timeframes; revising provider network directories to include telephone numbers, any known provider limitations in accepting new members, the non-English languages spoken by current providers and any physical restrictions of the provider's premises; and monitoring contracted providers to determine adequate capacity of the network.

Several of the required follow-up actions are related to the quality management of member services surround the annual quality assurance/quality improvement (QA/QI) workplan. Most CMOs need to conduct an evaluation of the previous year's QA/QI workplan in order to effectively develop the workplan for the coming year. In addition, opportunities exist to include quality monitoring activities (such as conducting internal file reviews, obtaining member feedback, and reviewing the use of clinical practice guidelines) in the QA/QI workplan to determine if CMOs are implementing effective care planning processes.

In addition, opportunities exist to develop or amend policies and procedures to ensure CMO staff are aware of management expectations regarding the dissemination of information to members, timelines related to the appeal and grievance process and issuance of notice of action forms, and processes for service authorization and requesting out-of-network providers.

MetaStar is currently monitoring each CMO's Improvement Plan and will review their progress during the next annual quality review.

III. Validation of Performance Measures

Background/Purpose of Review Activity

The Department of Health and Family Services (the Department) requires Family Care CMOs to collect and report information on certain performance measures each year. For 2005, these measures were:

- **Care management team turnover** - Percent of care management team members who separated during the reporting period
- **Influenza Immunizations** - Percent of CMO members who were continuously enrolled in the CMO between September 1, 2005, and December 31, 2005, and who received an immunization anytime between September 1, 2005 and March 31, 2006
- **Pneumonia immunizations** - Percent of CMO members who were continuously enrolled in the CMO during July 1, 2005, and December 31, 2005, and who received an immunization between January 1, 1995, and December 31, 2005

The Department directs MetaStar to perform a collegial review of the performance measures to ensure they are accurate and reliable. MetaStar also gives the CMOs constructive feedback to help them monitor their performance measures more effectively.

Review Methodology

Separation Measure

CMOs reported care management team turnover as the percentage of care management team members who separated during the calendar year 2005. The care management team consisted of two groups, which were reported separately: case managers and registered nurses. The CMOs were asked to calculate the rates for this performance measure.

Immunization Measures

For the 2005 contract year, MetaStar calculated rates for influenza immunizations among members who were continuously enrolled from September 1, 2005, through December 31, 2005 – the period during which they would have received current influenza immunizations. The rate was calculated as the percentage of these members who were known by the CMO to have received an influenza immunization during that period.

The pneumonia immunization rate was calculated as the percentage of members who were known by the CMO to have received a pneumonia immunization within the past 10 years (on or after January 1, 1995). The pneumonia immunization rate was calculated for members who were continuously enrolled from July 1, 2005, through December 31, 2005.

To ensure accurate and efficient reporting, MetaStar asked each CMO to create a table in an Access database file or an Excel spreadsheet file with specific data elements. They could report

influenza and pneumococcal immunizations in one table or two tables (one table for each immunization type).

Required Data Elements for Influenza and Pneumococcal Immunization Files

- Member name
- Member ID
- Date of birth
- Type of immunization
- Date of immunization If only the month and year were known, MetaStar instructed the CMO to default to the 1st day of that month. For pneumococcal immunizations, if only the calendar quarter was known, the CMO could default the date to the first day of the quarter.
  - If MetaStar decided any immunization date was not specific enough, the event may not have been counted as a numerator event. MetaStar conducted a follow-up review of service record to determine whether to include these immunizations in the measure's numerator.
- Contraindications if applicable
  - Members with contraindications were excluded from the measure denominator.
- Refusal
  - Members who refused the immunization were excluded from the measure numerator.

Findings & Analysis

Separation Measure

Four of the five CMOs collected valid separation data and calculated accurate separation rates. The CMOs' contracts required these data to be reported by March 1, 2006. As of May 31, 2006, one CMO did not report separation data to MetaStar.

Rates for care management team turnover

The following table shows the 2005 separation rates in comparison to the 2004 rates for care managers and registered nurses at each CMO.

CMO	Care Managers		Registered Nurses	
	2004	2005	2004	2005
Fond du Lac	13.0% (3/23)	19.2% (5/26)	11.1% (2/18)	26.3% (5/19)
Portage	0.0% (0/18)	13.6% (3/22)	11.1% (1/10)	0% (0/11)
Milwaukee	18.9% (36/190)	Not reported	22.0% (24/109)	Not reported
Richland	10.0% (1/10)	16.7% (2/12)	50.0% (4/8)	25.0% (2/8)
La Crosse	0.0% (0/43)	6.9% (5/72)	8.7% (2/23)	8.3% (5/19)

Two CMOs (Portage and Richland) showed a significant decrease in RN turnover rates between 2004 and 2005. The Portage CMO also showed a significant increase in Care Manager turnover in the same time period. It should be noted that CMOs vary greatly in terms of the number of staff employed. Because of this, a smaller CMO that loses one employee will show a larger separation rate than a CMO with a larger staff.

Immunization Measures

In 2005, all CMOs collected valid immunization data.

Rates for influenza and pneumonia immunization

Each CMO reported the number of members it knew had been vaccinated. From the data reported by each CMO, MetaStar was able to calculate usable rates for all CMOs. It is important to note that other members may have received immunizations without the CMO's knowledge. The tables below show the 2005 immunization rates that MetaStar calculated for each CMO, by target group.

2005 Influenza Immunization Rates by Target Groups

Target Group	Fond du Lac	Portage	Milwaukee	Richland	La Crosse	Aggregate
Frail Elderly	89.8% (377/420)	80.8% (308/381)	74.1% (3815/5147)	81.5% (101/124)	83.0% (455/548)	76.4% (5056/6620)
Physical Disabilities	67.6% (100/148)	61.5% (107/174)	54.3% (50/92)	56.8% (46/81)	64.5% (349/541)	62.9% (652/1036)
Developmental Disabilities	54.7% (182/333)	51.3% (119/232)	76.3% (29/38)	52.5% (52/99)	54.5% (262/481)	54.4% (644/1183)
Unspecified Disability*	NA	NA	NA	NA	0% (0/1)	0% (0/1)
All Target Groups	73.1% (659/901)	67.9% (534/787)	73.8% (3894/5277)	65.5% (199/304)	67.9% (1066/1571)	71.9% (6352/8840)

* “Unspecified Disability” per DHFS denominator file.

2005 Pneumonia Immunization Rates by Target Groups

Target Group	Fond du Lac	Portage	Milwaukee	Richland	La Crosse	Aggregate
Frail Elderly	55.3% (226/409)	37.7% (135/358)	60.9% (3010/4943)	60.5% (72/119)	73.2% (388/530)	60.2% (3831/6359)
Physical Disabilities	39.4% (56/142)	24.6% (41/167)	56.3% (49/87)	44.4% (36/81)	56.3% (297/528)	47.7% (479/1005)
Developmental Disabilities	17.8% (58/325)	16.1% (37/230)	54.3% (19/35)	25.5% (25/98)	29.7% (141/474)	24.1% (280/1162)
Unspecified Disability*	NA	NA	NA	NA	0% (0/1)	0% (0/1)
All Target Groups	38.8% (340/876)	28.2% (213/755)	60.8% (3078/5065)	44.6% (133/298)	53.9% (826/1533)	53.8% (4590/8527)

* "Unspecified Disability" per DHFS denominator file.

The following table compares the 2004 and 2005 immunization rates for all target groups for each CMO.

2004/2005 Overall (all Target Group) Immunization Rates by CMO

CMO	Influenza Immunization		Pneumonia Immunization	
	2004	2005	2004	2005
Fond du Lac	65.3%	73.1%	41.5%	38.8%
Portage	65.4%	67.9%	22.6%	28.2%
Milwaukee	72.3%	73.8%	60.2%	60.8%
Richland	39.7%	65.5%	33.1%	44.6%
La Crosse	57.4%	67.9%	49.7%	53.9%
All CMOs	**67.3%**	**71.9%**	**52.3%**	**53.8%**

The immunization rates showed little change or improvement from 2004 to 2005 for most CMOs. However, the Richland CMO demonstrated a 65% increase in its influenza immunization rates between 2004 (39.7%) and 2005 (65.5%). Although influenza vaccinations were not in short supply during the 2005 influenza season, the Portage CMO and the Milwaukee CMO showed only minimal improvement in influenza immunization rates. Most CMOs improved their pneumococcal immunization rates slightly, although Fond du Lac CMO showed a decrease in pneumococcal immunization rates.

CMOs should continue to work to improve their immunization rates. These immunizations have been shown to be effective in preventing flu and pneumonia – conditions that can be serious, and even fatal, for the populations served by the Family Care program (i.e. frail elders and person with disabilities).

Summary

All CMOs reported valid data in 2005. Overall, there has been little change or improvement in immunization rates from 2004 to 2005, except for Richland CMO, who demonstrated a 65% increase in influenza rates between 2004 and 2005. Portage and Milwaukee CMOs showed minimal improvement in influenza rates. Most CMOs improved the rate of pneumococcal immunizations slightly, with the exception of Fond du Lac CMO, who showed a decrease.

It is difficult to draw conclusions from the separation data, given that CMOs varied greatly in the number of staff they employ.

IV. Validation of Performance Improvement Projects

Background/Purpose of Review Activity

Annually, each CMO must conduct two performance improvement projects (PIPs) and implement or complete them in a reasonable time period. Each organization must also provide a report to the Department on the status and results of each project that is underway or initiated. This report must include enough detail to show that the CMO is making progress toward full implementation of each project. MetaStar is then expected to review and validate each PIP and provide a written feedback report of its findings to the Department and to each CMO.

The goal of this validation process is to ensure that the CMO is using proper technique and design so that it can use the project's data and findings to improve.

In 2005, all CMOs used the Center for Health Care Strategies' *Best Clinical and Administrative Practices (BCAP)* model for improvement, which was developed specifically for Medicaid organizations. The model focuses on these steps:

- Initial needs assessment to identify improvement opportunities
- Typology to address typical issues for Medicaid populations, including identification, stratification, outreach and intervention
- Ongoing measurement
- Rapid cycle improvement
- Sustainability
- Diffusion and sharing of best practices

Review Methodology

Based on the Center for Medicare and Medicaid Services (CMS) *Protocol for Validating PIPs,* evaluating PIPs involves two activities: assessing the organization's methodology for conducting the PIP; and verifying actual PIP findings. During 2005, MetaStar contracted with the Department only to assess the CMO's methodology for conducting their PIPs. This included the following steps:

- Review of the project topics – to ensure they adequately reflected the CMO's enrolled population
- Review of the project aims – to ensure that CMOs included numerical goals and target dates in project aims
- Review of selected project indicators – to determine if they were clear, measurable and based on current clinical knowledge or health services research
- Review of project populations and sampling methods – to determine whether all or part of the population was used and how it was captured and selected

- Review of data collection procedures – to determine if data collected for the PIP indicators was valid and reliable. This included an assessment of data sources, data collection instruments, and training and/or qualifications of data collectors
- Assessment of improvement strategies – to determine if real, sustained improvements resulted from continuous cycles of measuring and analyzing performance
- Review of the CMO's data analysis and interpretation of results – to determine the CMO's use of appropriate statistical analysis techniques
- Assessment for "real" and "sustained" improvement in projects showing improvement

CMOs submitted their projects for review using the BCAP workbook and cover and summary addendums. After the review, each CMO received a preliminary report of findings and had a chance to comment or respond to those findings. MetaStar incorporated any responses into a final report for each project.

Findings and Analysis

In 2005, each CMO initiated two PIPs. One CMO was unable to fully implement one of its projects due to ongoing staffing issues. Project topics are shown below.

2005 BCAP Performance Improvement Project Topics

CMO	Project Topic #1	Project Topic #2
Fond du Lac	Advance Directives	Increasing Influenza Vaccine Use
La Crosse	Diabetes	Nursing Home Utilization
Milwaukee	Preventing/Delaying Placements Through Medication Management	Member Outcomes: Improving Supports Present
Portage	Increasing Influenza Vaccine Use	Congestive Heart Failure (CHF)
Richland	Power of Attorney for Health Care	Immunizations

Each CMO should have a defined process for prioritizing and selecting project topics based on a thorough needs assessment and review of available data. All CMOs chose topics that were relevant to their members. However, it was not always clear how the CMOs selected their project topics from among others. It was also noted that the CMOs did not always consider relevant data, such as claims data, utilization data, enrollment data, quality data, or other data specific to the topics being considered before undertaking a project. Some CMOs started projects before establishing the need for improvement. For example, one project was aimed at members with a specific clinical condition (congestive heart failure). However, the project team didn't establish the prevalence of CHF among its members until well over a year into the project. Undertaking a performance improvement project before establishing the need for improvement can result in inappropriate utilization of staff time and organizational resources.

With help from MetaStar staff, CMOs began to think about and develop overall project indicators that measured important outcomes for members. CMOs also worked closely with MetaStar staff to develop clearly stated, measurable aims that included numerical goals and target dates.

Most projects clearly defined the "relevant" population (the population at which the project was aimed). However, in a few projects, the relevant project population was identified, but not clearly defined. For example, one project was aimed at increasing the number of members with advanced directives in place. Since there are several different types of advanced directives (e.g. Power of Attorney for Finance, Power of Attorney for Health Care, legal guardianship, living wills, etc.) and in some cases members may have more than one advanced directive in place, it would be important to know how many and what type of advanced directives were needed for a member to qualify as "having advanced directives." It was noted that this lack of definition created confusion among the project team. This may have led questionable project data that may not have been accurate or valid. When the validity of data is questionable, it should not be used for decision-making.

As part of developing a performance improvement project, each CMO should clearly define the data needed for project measures, and should identify how and by whom that data will be collected. This helps ensure that the data being collected is what is wanted and that it is collected in a valid and reliable way. Valid, reliable data is necessary if it is going to be used for decision-making purposes. While most CMOs collected monthly data, few provided samples of data collection instruments or descriptions of how data was collected and by whom.

Most projects included improvement strategies that appeared to have a high likelihood of resulting in improvement. When intervention strategies did not work or became stalled, project teams were able to identify barriers and methods to address them. Approximately half of the projects were far enough along to collect baseline and repeat measurements. Of these projects, most were able to show some improvement toward their overall aim.

Throughout the year, MetaStar provided each CMO with ongoing one-on-one technical assistance with their PIPs. This assistance included conference calls to the project teams. During these calls, it was clear that project teams still needed help in designing projects and applying the BCAP typology to new projects. Also, some CMO staff did not understand the importance of measuring overall progress and did not understand how to measure the effectiveness of interventions.

MetaStar also facilitated quarterly workgroups for project teams. These workgroups gave project teams an opportunity to share their ideas, successes and challenges. Initially time was allotted during workgroups to provide teams with additional one-on-one technical assistance from MetaStar and Department staff. Feedback solicited from workgroup participants showed that they preferred to use workgroup time for quality improvement education and group sharing, rather than for additional one-on-one technical assistance. They felt that MetaStar provided technical assistance adequately in an on-going fashion throughout the year.

Summary

CMOs should continue to select topics of relevance for Family Care members in order to ensure that organizational recourses are being used efficiently. Teams should also continue to develop outcome measures for each project. Frequent data collection on outcome measures will help project teams track overall progress. Teams should also continue to test interventions on small sample or pilot groups to ensure that they will be effective in producing desired change and/or improvement.

For future projects, CMOs should use all available and relevant data when identifying and prioritizing opportunities for improvement. Quarterly workgroups should continue, with a focus on quality improvement education and increased time for group sharing of progress. MetaStar will continue to gather feedback from workgroup participants to identify potential topics of interest and will continue to provide one-on-one technical assistance as needed and requested by project teams.

V. Assessing the Quality of Service and Support Coordination Functions

Background/Purpose of Review Activity

The purpose of the Member Centered Assessment and Plan (MCAP) review is to determine how well the CMO coordinates health and long term care services and for its members. The review assesses four focus areas:

- Care management functions of the CMO
- Continuity and coordination of care
- Coverage and authorization of services
- Implementation of practice guidelines

The MCAP review looks at how well the CMO is using the assessment and planning process to identify a member's desired outcomes and to coordinate services and supports for the member. It also looks at whether the CMO is writing service plan goals that reflect the member's stated desires and preferences.

In 2005, MCAP reviews expanded to include an assessment of the systems and processes each CMO had in place to support care management functions and how effectively those processes were working for the CMO and its members.

Review Methodology

The 2005 MCAP review process consisted of several components described below.

Document Review

MetaStar requested and reviewed documents specific to practice guidelines, continuity and coordination of care, and coverage and authorization of services. The table below lists the criteria MetaStar used to evaluate these documents.

Document Focus Area	Criteria
Practice Guidelines	• Guidelines are evidence-based, reflect the needs of the enrolled population, are developed in consultation with affiliated providers, are periodically updated, and are communicated to enrollees and affected providers. • Policies and procedures are in place to assure that decisions about services and supports are consistent with practice guidelines. • Clinical guidelines include an overview of the condition/disease; contain information related to recognizing and responding to the condition/disease; and incorporate the condition/disease into a

Document Focus Area	Criteria
	prevention and wellness plan as part of the care planning process. • There is a plan for monitoring the effectiveness of guidelines.
Coverage/Authoriz a-tion of Services	• Policies and procedures are in place that describe criteria for making service authorization decisions, including timeframes for responding to requests that comply with State and Federal requirements, • Mechanisms are in place to ensure that appropriate professionals are involved in service authorization decisions and that service authorization criteria are consistently applied. • A process exists for expediting responses to urgent/emergent requests and for notifying members of service authorization decisions.
Continuity and Coordination of Care	• Mechanisms are in place to ensure that a face-to-face assessment of the member's needs, strengths, preferences and outcomes is completed and that a person or entity is formally designated as primarily responsible for coordinating the member's overall long term care and health needs. • Mechanisms are in place to ensure coordination of covered and non-covered services and coordination of community and other social programs. • Mechanisms are in place to ensure that members/guardians, family and informal supports take part in care planning. • A policy is in place that specifies minimum contact standards for interdisciplinary teams. • Processes are in place to ensure the health and welfare of members and to evaluate and improve performance in the area of safety and risk; and prevention and wellness services are available to members. • Assessment and care planning processes include all required elements specified in the CMO's contract with the Department.

Management/Leadership Interviews

MetaStar then interviewed the CMO management/leadership team to clarify how the policies, procedures and processes identified in the documents were implemented and to assess their perceived effectiveness. The CMO staff attending this interview included the CMO director (and assistant Director, if applicable), quality management staff and supervisors. The interview was designed to obtain information about the CMO's practice guidelines; processes for coverage and authorization of services; and policies and procedures related to continuity and coordination of care.

Member File Review

MetaStar conducted an on-site review of a sample of member service plans. The review looked at how well the CMO complied with regulations set out in the Family Care Statute and Rule and in its contract, and at the quality of the services the CMO provided its members. The review process included a protocol to address immediate, serious concerns in a timely manner.

Member File Review Criteria

The 2005 criteria for evaluating member-centered assessments and plans included priority and non-priority criteria. Priority criteria were directly associated with achieving member outcomes and assuring the health and welfare of members. The minimum performance level for the priority criteria was 95 percent. If a CMO fell below that level in any of the priority criteria, it was required to take corrective action. If the review noted trends in areas other than the designated priority areas, follow-up was recommended. MetaStar monitored all corrective action and recommended follow-up.

Priority criteria were:

- Completing an initial comprehensive health assessment
- Completing an initial comprehensive social assessment
- Incorporating member outcomes into a member-centered plan (MCP)
- Assuring coordination of covered services
- Assuring coordination of non-covered services
- Addressing all identified needs of members
- Ensuring that all services listed on the individualized service plan (ISP) are provided

The other non-priority criteria related to timeless of service planning, member-centered focus and other quality indicators related the quality and comprehensiveness of care management services.

Care Manager/Nurse Interviews

MetaStar conducted focus groups with care managers and nurses from each CMO. The discussion explored how they believed policies and procedures related to care management functions were working for the teams and members. MetaStar also obtained information about practice guidelines; processes for coverage and authorization of services; and policies, procedures and processes for continuity and coordination of care.

Data Analysis and Reporting

After completing all reviews and interviews, MetaStar compiled and analyzed the data. Data from the member file review was entered into a central database for tracking and trending. Each CMO received a draft report of the findings from the member file review that included corrective action required by the Department and any recommendations for follow-up. The CMO could respond to the draft report before it was finalized. CMO responses and those comments were incorporated into the final report. The table below summarizes the number of MCAP reviews and disenrollment reviews MetaStar completed for 2005.

2005 MCAP and Disenrollment File Review Counts

CMO	MCAP Reviews	Disenrollment Reviews
Fond du Lac	28	2
La Crosse	30	4
Milwaukee	93	21
Portage	26	4
Richland	25	5
TOTAL	**202**	**36**

Findings and Analysis

Finding from Priority Criteria

The table below summarizes the 2005 MCAP findings for the priority criteria.

2005 Findings by County – MCAP Review of Priority Criteria

Criteria	Fond du Lac (% met or N/A)	La Crosse (% met or N/A)	Milwaukee (% met or N/A)	Portage (% met or N/A)	Richland (% met or N/A)	All CMOs (% met or N/A)
Completed health assessments	100	100	100	100	100	100
Completed social assessments	100	100	100	100	100	100
Incorporated member outcomes	100	100	97.8	100	100	99
Coordinated covered services	100	100	79.6	100	100	90.6
Coordinated non-covered services	100	96.7	92.5	100	96	95.5
Addressed all identified needs	100	96.7	90.3	100	100	95
Provided ISP services	100	100	97.8	100	100	99

Findings from Other Criteria

The tables below show the 2005 results for non-priority criteria:

2005 Findings by County – Timeliness of Service Planning

Criteria	Fond du Lac (% met or N/A)	La Crosse (% met or N/A)	Milwaukee (% met or N/A)	Portage (% met or N/A)	Richland (% met or N/A)	All CMOs (% met or N/A)
Health assessments completed within 30 days	75	93.3	91.4	100	72	88.1
Social assessments completed with 30 days	96.4	93.3	91.4	100	88	93.1
Initial ISP completed and signed within 10 days	78.6	93.3	63.4	96.2	96	78.2
MCP completed and signed within 60 days	81.5	86.7	68.8	76.9	76	75.1
MCPs updated within that last six months	92.9	96.7	89.1	88.5	100	92
Service authorization decisions made within required timeframes	100	88.2	86.7	100	100	91.7

2005 Findings by County – Member-Centered Focus

Criteria	Fond du Lac (% met or N/A)	La Crosse (% met or N/A)	Milwaukee (% met or N/A)	Portage (% met or N/A)	Richland (% met or N/A)	All CMOs (% met or N/A)
Member preferences for services and supports incorporated into the plan	100	100	98.9	100	100	99.5
Member lives in preferred living arrangement or agrees to the substitution	92.9	96.7	96.8	100	100	97.0
Notices of action issued when indicated	100	100	50	85.7	50	70.6

2005 Findings by County – Other Quality Indicators

Criteria	Fond du Lac (% met or N/A)	La Crosse (% met or N/A)	Milwaukee (% met or N/A)	Portage (% met or N/A)	Richland (% met or N/A)	All CMOs (% met or N/A)
Health assessments were comprehensive	100	93.3	96.8	96.1	100	97
Social assessments were comprehensive	86	80	98.9	100	96	94.1
Reassessments performed when indicated	100	100	97.8	100	100	99
Risk assessments completed when indicated	100	90	97.8	100	100	97.5
Risk was addressed with member	100	100	100	100	100	100
MCP/ISPs explained how and by whom acute and primary care was coordinated	100	100	82.8	100	100	92.1
Files complete and available	100	100	98.9	84.6	100	97.5
All basic needs and serious health/safety issues were addressed	100	100	97.8	100	100	96.5

Trending

In 2003 and 2004, MetaStar used a different review procedure than in 2005. After the initial review was completed, CMOs could provide additional information to address issues or concerns identified during that review. That additional information was incorporated into the final reported findings. In 2005, MetaStar used a single level process, reporting only the initial review findings as final. To provide a more accurate comparison, the findings listed below for 2003 and 2004 are the preliminary findings (before the CMO had an opportunity to correct issues).

MetaStar does not review all criteria every year. The table below that compares the aggregate (all CMO) findings from 2003 through 2005 includes only the criteria that were reviewed in more than one year.

Priority Criteria	2003 *n*=404	2004 *n*=309	2005 *n*=202
	% of Criteria Met or N/A		
Completing health assessments	99.5	N/A*	100
Completing social assessments		N/A*	100
Incorporating member outcomes	92.1	94.8	99
Coordinating covered services	99.5	98.7	90.6
Coordinating non-covered services	96.5	68	95.5
Addressing all identified needs	77.5	90.3	95

Timeliness of Service Planning Criteria	2003 *n*=404	2004 *n*=309	2005 *n*=202
	% of Criteria Met or N/A		
Health assessments completed within 30 days	87.5	N/A*	88.1
Social assessments completed with 30 days		N/A*	93.1
Initial ISP completed and signed within 10 days	82.5	N/A*	78.2
MCP completed and signed within 60 days	82.5	N/A*	75.1
MCPs updated within last six months	92.6	94.8	92

Member-centered Focus Criteria	2003 *n*=404	2004 *n*=309	2005 *n*=202
	% of Criteria Met or N/A		
Member preferences are incorporated into the plan	96.5	99.3	99.5
Member lives in preferred living arrangement or agrees to substitution	99	100	97.0
Notices of action issued when indicated	73.8	75.8	70.6

Other Quality Indicators	2003 *n*=404	2004 *n*=309	2005 *n*=202
	% of Criteria Met or N/A		
Health Assessments were comprehensive	96.4	N/A*	97
Social Assessments were comprehensive		N/A*	94.1
Reassessments performed when indicated	99	89	99
Risk was addressed with member	97.8	91	100

** In 2004, all plans reviewed were plans of members who were enrolled for more than one year. Therefore, the initial timeframes for assessments and initial ISPs and MCPs was not reviewed.*

Priority Criteria – Assessments and Service Planning

The CMO's contract with the Department requires it to complete an initial comprehensive assessment and a member-centered plan for every new Family Care member. The initial assessment is the first step in effective member-centered planning. It is the primary means by which the CMO identifies the member's needs, strengths, and desires. Next, the CMO incorporates this information into a unique member-centered plan designed to help the member achieve their self-identified outcomes or goals.

Over time, CMOs have improved their performance in completing health and social assessments for new members, and in identifying and incorporating member outcomes into individualized member-centered plans.

Priority Criteria – Service Coordination and Service Delivery

Coordinating services is a primary function of care management. In Family Care, the interdisciplinary team (IDT) is responsible for coordinating the member's overall health and long-term care needs. This includes coordinating services covered under the Family Care benefit (e.g. personal care, supportive home care, DME, home-delivered meals, etc.) as well as coordinating services not included in the benefit package (e.g. acute and primary care, dental services, Medicare-covered services such as skilled therapies, etc.).

Most CMOs were actively working to ensure that both covered and non-covered services were coordinated. However, one CMO (Milwaukee) did not meet the established minimum performance level of 95 percent for these criteria. Interviews with CMO staff and IDT members revealed barriers such as a service authorization process that was time- and labor-intensive, processes that were not well-communicated and processes that were not used consistently throughout the organization. Also, the CMO did not have an internal monitoring system to evaluate the quality of services being provided.

Of note, trending data showed a significant decrease in activities related to coordinating non-covered services in 2004. This may have been a result of MetaStar's focused study of diabetes care management that was conducted in conjunction with the MCAP review that year. MetaStar reviewers may have been looking more closely at the coordination of acute and primary care services related to diabetes, such as physician office visits, eye care, dental care and foot care, more closely in 2004 than in previous years. This could mean that the data collected from 2004 and prior years were reviewed under different standards, making it inappropriate for comparison.

Another function of the IDT is to assure that members actually receive services that the IDT has authorized or arranged. To assess this, reviewers compared authorized ISP services to paid claims. When claims were not available to reviewers, it was usually due to lag time in claims submission. In these instances, case notes often provided evidence that the IDT had followed up with members to ensure that services were actually provided as authorized.

Timeliness

Family Care CMOs have specific requirements for the timing of conducting assessments and developing service plans. Timely service planning ensures that service delivery is not delayed, so that members get services that are critical to their health and well-being. The timeliness of service planning shows minimal improvement over time. During staff interviews in 2005, MetaStar learned that most CMOs do have some level of internal tracking to monitor timelines for service planning. However, few CMOs analyze or use this information regularly. The Milwaukee CMO did not have an internal monitoring system in place, and the Fond du Lac CMO was in the early stage of implementing a monitoring system.

Some staff identified barriers to completing assessments and plans in a timely manner. These included not being able to reach members or members not showing up for scheduled appointments. Some cited staffing shortages as a barrier to meeting the required timeframes.

Member-Centered Focus

Creating and fostering a member-centered approach to service planning and service delivery is a key aspect of the Family Care philosophy. This approach is based on the belief that members, not providers, should determine what results they want and need from the services and supports they receive. A key component of this system is an interdisciplinary team that listens to members to identify their values and preferences, and then incorporates what they learn into an individualized plan of care. The 2005 MCAP findings indicate that CMOs have embraced this philosophy, creating a strong member-focused approach to care management.

However, opportunities continue to exist for improving processes related to issuing notices of action to members when service requests are denied or services are limited. Notices of action are instrumental in ensuring that member rights are upheld, because they give members written information about their appeal and grievance rights. Three of the five CMOs showed adverse trends in issuing notices of action. Discussions with IDT staff at these CMOs revealed that they not always sure when a notice of action was needed. Reviewers discovered that one CMO was using two different forms, each of which contained appeal and grievance information. Using two forms with similar appeal and grievance language caused confusion among staff as to which form was actually the required notice of action form.

Other Quality Indicators

IDTs are identifying and addressing risk with members. This was evidenced by the use of risk assessments and risk agreements when they were indicated. IDTs are also completing reassessments when members' conditions or needs change.

One area noted for improvement in Fond du Lac and La Crosse CMOs was the comprehensiveness of social assessments. Both counties had, or were in the process of implementing, an internal process for monitoring the timeliness of initial service planning requirements. However, these processes did not include a way to monitor the quality or comprehensiveness of assessments.

Another opportunity for improvement is at the Milwaukee CMO, related to including information on MCPs/ISPs about how effectively members' acute and primary care needs are being coordinated. Plans should include information about how the member's primary heath care needs are being coordinated; however, this was not always seen in Milwaukee CMO plans. Even after discussions with IDT staff about their role in coordinating acute and primary care for members, it was still not clear why this was observed less often in Milwaukee CMO members' plans. Staff expressed an emphasis on the health care needs of members; however, they did identify some barriers including the fact that IDTs may not be clear about how to document this type of coordination. Also, IDTs may not understand that even if the CMO is not coordinating this care (i.e. a family member or informal support is taking responsibility for this), they still must identify and document who is responsible for making sure that the coordination occurs.

There were also four cases at the Milwaukee CMO where reviewers identified serious health and safety concerns. Two of these cases were from one care management unit (CMU) and involved concerns about the professional qualification of their employed staff. These cases were referred to the Department for follow-up.

Corrective Action Plans

The Milwaukee CMO was required to initiate a corrective action plan that was triggered by several findings. First, the CMO did not meet the established performance level of 95 percent in three priority areas. Second, adverse trends were noted for several other areas. In addition, the review identified four cases that raised serious health and/or safety concerns. At the time of the review, the CMO did not have an approved quality management program in place.

The Department and MetaStar worked collaboratively with the CMO to develop a corrective action plan, which included the following steps:

- Presenting the 2005 MCAP Review Findings to the CMO Governing Board
- Recruiting and Selecting a DHFS-approved Director of Clinical Operations with sufficient expertise in health care quality management principles and practice to oversee the development and implementation of the CMO's quality management program.
- Developing and implementing an internal monitoring system to include an internal file review process similar to MetaStar's MCAP review and an overall monitoring plan for assuring quality of care management services.
- Performing an administrative review of the CMU where the two cases with staff qualification issues were identified.
- Implementing a process to assure that all care managers and care management teams meet contract requirements for professional qualifications.

To date, the Milwaukee CMO has hired a Department-approved Chief Operating Officer who is overseeing the CMO's quality management function. It has also begun to implement an internal monitoring program to evaluate the quality of services being provided to members. The CMO has worked closely with MetaStar and the Department in the design and implementation of this program. As part of this monitoring program, the Best Practice Team (contracted by the CMO to provide quality management services) is completing monthly file reviews and submitting its findings to MetaStar and the Department. File review findings are then discussed during monthly conference calls with MetaStar and the Department. The CMO is continuing to work with its CMUs to ensure they are employing appropriately qualified staff.

Summary

All CMOs have processes in place for completing initial comprehensive assessments that identify members' needs, strengths, and preferences. Interdisciplinary teams (IDTs) are also reassessing members when significant changes occur. IDTs utilize a member-focused approach to service planning and delivery by identifying and incorporating member preferences and outcomes into individualized member-centered plans. Team members frequently follow-up with members to ensure that authorized services are implemented and that risk is addressed when identified.

CMOs have an opportunity to implement internal monitoring processes for evaluating the timeliness and quality of service planning and delivery for members. Internal monitoring helps ensure the quality of services and supports being provided to members. CMOs should evaluate the types of routine monitoring currently in place within the organization. A good internal monitoring plan should include a description of the methods by which reviews occur; the frequency of reviews; person(s) responsible for conducting reviews; data collection instruments and a plan for how reviewers will be trained; how and by whom data will be compiled and analyzed; and how findings will be used and shared with other staff.

CMOs also have an opportunity to improve their process for issuing notices of action to members when service requests are limited or denied. This is important because the notice of action contains information for members regarding their appeal and grievance rights when they do not agree with decisions that the CMO has made. Each CMO should review its internal process for issuing notices of action to determine if changes in the process are needed or if additional training for staff is indicated.

There continues to be several opportunities for the Milwaukee CMO to improve its processes related to service planning and delivery. A well-defined quality management plan, that includes an active internal monitoring process is necessary to help identify areas needing improvement. The Milwaukee CMO should continue to work closely with the Department and MetaStar as it continues to carry out the steps identified in their current corrective action plan. The Milwaukee CMO should continue to participate in monthly updates and conference calls with the Department and MetaStar until significant improvement is achieved.

Attachment A: Appeals and Grievances 2005 Annual Report

Background

The Department of Health and Family Services (DHFS) authorizes MetaStar to investigate Family Care appeals and grievances submitted to DHFS. MetaStar also performs concurrent reviews on any appeal not related to eligibility issues that is submitted to the Division of Hearing and Appeals (DHA), and sometimes, conducts concurrent reviews on eligibility related matters as directed by DHFS. Last, MetaStar tracks and documents any local adverse decisions that are submitted to DHFS by the Family Care CMOs, per contract guidelines.

DHFS can use the review of appeals and grievances to measure the quality of services, in conjunction with other quality review activities. The occurrence of several appeals and grievances in a certain area may indicate a trend that requires further review.

The Appeals and Grievances Annual Report provides an overview of the number and types of appeals and grievances that occurred in 2005.

For tracking and analysis purposes, each appeal and grievance is categorized into one of five general categories shown below.

Eligibility related issues: • Denial of eligibility, entitlement or enrollment • Delay in determination of eligibility, entitlement or enrollment • Eligibility issues related to divestment of funds • Issues related to spousal impoverishment • Determination of cost sharing • Estate recovery • Recovery of incorrectly paid benefits
Requested Services issues: • Denial of a service or support • Limited authorization of type/amount of service • Reduction, suspension or termination of service • Failure to provide services or supports authorized in the member-centered plan in a timely manner
Service Plan issues: • Requiring a member to live in a place that is unacceptable to the member • Not providing sufficient care, treatment or support to meet member's needs or identified outcomes • Service plan requires the member to accept care, treatment or support that is unnecessarily restrictive • Service plan requires the member to accept unwanted care, treatment or support
CMO Decisions: • Failure to act within grievance and appeal process timelines • Other decision, omissions or actions

General Grievances:

- Failure to act within the grievance and appeal process timelines
- Other decisions, omissions or actions

Overview of Appeals and Grievances: 2005

In 2005, 111 appeals and grievances were filed with either DHFS or DHA by a total of 97 unique Family Care members. This represents a 26% reduction from the 150 appeals and grievances that were filed (by 140 unique Family Care members) in 2004. Some members filed in both the DHFS and DHA level for the same issue.

The largest number (45) of DHFS and DHA Concurrent reviews investigated related to requested services. Eligibility issues also comprised a high number of appeals, mainly from Milwaukee CMO.

2005 Appeals and Grievances Filed (includes DHFS and DHA Level)

CMO	Eligibility		Requested Services		General Grievances		Service Plans		Total (n=111)	
	DHFS	DHA	DHFS	DHA	DHFS	DHA	DHFS	DHA	DHFS	DHA
Fond du Lac	0	0	8	6	5	1	1	1	**14**	**8**
La Crosse	0	6	2	6	0	0	0	0	**2**	**12**
Milwaukee	2	40	9	11	7	0	1	0	**19**	**51**
Portage	0	1	1	1	0	0	0	0	**1**	**2**
Richland	0	0	2	0	0	0	0	0	**2**	**0**
TOTAL	**2**	**47**	**22**	**24**	**12**	**1**	**2**	**1**	**38**	**73**

DHA Fair Hearings

In 2004, there were a total of 91 requests for DHA State fair hearings. In 2005, 73 requests for State fair hearings were made. This represents a 20% reduction in overall requests for State fair hearings. A large number of requests for fair hearings were for issues related to eligibility.

In 2004, only two CMOs, Milwaukee and Fond du Lac, had members who filed with the State for a fair hearing. In 2005, La Crosse CMO had a significant increase in the number of requests for fair hearings (12 filed in 2005 versus 0 filed in 2004), and Portage CMO had two requests.

DHFS Level Appeals and Grievances

MetaStar conducts an investigation of all appeal and grievance requests made to DHFS. In 2004, there were a total 20 requests for appeals or grievances at the DHFS level. In 2005, 38 appeals or grievances were made directly to DHFS. This represents a 47% increase in the number of DHFS level investigations. The highest number of issues was related to requested services. The number of general grievances that were filed also increased.

Appeal and Grievance by Target Group Population

Milwaukee CMO has the highest number of members (49) filing appeals and grievances in the Frail Elder (FE) target group. However, only two members in Milwaukee CMO's Physically Disabled (PD) target group filed an appeal or grievance. Fond du Lac and La Crosse CMOs had the highest proportionate number of members in the PD target group who filed an appeal or grievance.

2005 Appeals and Grievances Filed by Target Group

CMO	Developmentally Disabled (DD)		Frail Elder (FE)		Physically Disabled (PD)		Total (n=111)	
	DHFS	DHA	DHFS	DHA	DHFS	DHA	DHFS	DHA
Fond du Lac	6	2	1	1	7	5	**14**	**8**
La Crosse	1	3	0	4	1	5	**2**	**12**
Milwaukee	0	0	19	49	0	2	**19**	**51**
Portage	0	0	0	1	1	1	**1**	**2**
Richland	1	0	1	0	0	0	**2**	**0**
TOTAL	**8**	**5**	**21**	**55**	**9**	**13**	**38**	**73**
	Total DD n=13		**Total FE n=76**		**Total PD n=22**		**111**	

Resolutions Obtained by MetaStar (all DHFS and DHA Concurrent Review Types)

MetaStar conducts investigations on all appeals and grievances that are not related to eligibility. In certain circumstances, DHFS directs MetaStar to conduct DHA Concurrent reviews on eligibility related issues, such as cost share issues. In 2005, MetaStar reviewed only one eligibility issue.

2005 Appeals and Grievances Resolutions Obtained (includes DHFS and DHA Level)

CMO	DHFS Level Reviews		DHA Concurrent Reviews	
	Number of Reviews	Resolutions Obtained	Number of Reviews	Resolutions Obtained
Fond du Lac	14	7/14 (50%)	8	2/8 (25%)
La Crosse	2	0/2 (0%)	7	1/7 (14%)
Milwaukee	19	8/19 (42%)	11	1/11 (9%)
Portage	1	1/1 (100%)	1	0/1 (0%)
Richland	2	2/2 (100%)	0	n/a
Total Resolved	**DHFS: 18/38 (47%)**		**DHA Concurrent: 4/27 (15%)**	

The number of resolutions that occurred at the DHFS level increased in 2005. In 2004, MetaStar investigated 55 appeals or grievances, of which only 20 were successfully resolved. In 2005, MetaStar conducted fewer DHFS level investigations, but almost half of these were successfully resolved to the member's satisfaction.

Of the 73 DHA Fair Hearings filed, MetaStar conducted 27 DHA Concurrent reviews in 2005. MetaStar was able to informally resolve only 4 of the 27 DHA Concurrent investigations that occurred when members appealed at the State Fair Hearing level. The lower number of resolutions may reflect partial resolutions being obtained, but not enough for the Family Care member to cancel the State fair hearing. For example, an appeal may be made because the CMO

reduced care hours. When attempting resolution, MetaStar may have been able to negotiate a partial resolution that was not fully acceptable to the Family Care member; therefore, the case continued to the State fair hearing.

Adverse Decisions

In 2005, the CMOs submitted 34 adverse decisions to DHFS through MetaStar. This is a slight increase from the 31 received in 2004. Fond du Lac CMO had twice as many adverse decisions as last year. La Crosse CMO had the highest increase, going from only two adverse decisions in 2004 to nine in 2005. Milwaukee CMO had a decrease in the number of adverse decisions: in 2004, they submitted 21 adverse decisions, in 2005, they submitted 11. In response to this decrease, Milwaukee CMO reports that they have made greater attempts to resolve issues either before a local hearing (at the interdisciplinary team level) or at the hearing.

2005 Local Adverse Decisions Received

CMO	Number of Local Adverse Decisions Received
Fond du Lac	12
La Crosse	9
Milwaukee	11
Portage	2
Richland	2
TOTAL	**34**

2005 Requests for Milwaukee CMO Supportive Home Care Concurrent Review

Supportive Home Care (SHC) Concurrent Reviews in Milwaukee CMO began in 2004 and continued into 2005. These reviews occurred when the teams proposed a reduction or termination in the SHC services when a family member was being paid to provide the care. The SHC Concurrent review process only occurs for the Milwaukee CMO.

2005 Milwaukee CMO Supportive Home Care (SHC) Concurrent Reviews

Decision	Number of SHC Reviews
MetaStar determined reduction or termination in SHC services was appropriate	86
MetaStar closed the review as it was not related to the "Paying Family Caregiver" guidelines	45
DHFS Reviewed the SHC proposal as MetaStar did not determine the reduction or termination was appropriate, and subsequently approved the SHC proposal	24
TOTAL	**155**

In 2005, a total of 155 SHC Concurrent reviews were submitted by Milwaukee CMO. Of these, 86 were determined by MetaStar to meet the "Paying Family Caregiver" guidelines. Forty-five were determined to not be related to the guidelines, or not to require a review because the member requested the reduction, and were subsequently closed (no review occurred). Another 24 reviews were forwarded to DHFS for review and approval, as the MetaStar reviewer could not determine if they were appropriate. All 24 reviews that DHFS conducted were subsequently approved.

Sixty-six percent (103/155) of all reviews were conducted within five of 31 contracted Care Management Units (CMUs). The two CMUs with the highest number of requests were ANEW (42) and Jewish Family Services (22). The CCO/CCE CMU had 14 reviews, Carefinders CMU had 13 reviews and Horizon CMU had 12 reviews.

SHC Concurrent reviews will continue for Milwaukee CMO until DHFS determines it is no longer necessary to do so.

Appeal and Grievance Database Development

DHFS and MetaStar worked jointly in 2005 to begin developing a new appeals and grievance database. The goal of creating this new database is to develop a system that can meet the current needs of Family Care appeal and grievance activity and handle future growth. The database was developed with the specific needs of the Family Care program in mind, yet was intentionally structured to be flexible enough to adapt to needs of other Managed Care programs (i.e., WPP/PACE programs).

Key features of this new database include:

- Accessibility on the web for any authorized user;
- An improved ability to track similar appeals/grievances as members use the various systems available to them (i.e., member files with State fair hearing, DHFS, and their local CMO for reduction in SHC hours);
- Elimination of duplication of data entry for members already in the system and have more than one appeal or grievance;
- Ability for the appeal and grievance investigator to include notes and tasks in the database rather than in a separate file, and
- Increased information gathering capabilities.

MetaStar and DHFS began piloting the database in early 2006. Expansion to other programs, specifically WPP /PACE and development of additional reporting features has been occurring in 2006.